Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |            | (X2) MULTIPLE CONSTRUCTION A. BUILDING             |   | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|---|--|--|------------|--|---|-------------------------------|--------------------------|--|
| NVS597S   |  | NVS597S  |            | B. WING  |   | 03/27/2009                    |                          |  |
| NAME OF PROVIDER OR SUPPLIER                        |  |  | STREET ADD | RESS, CITY, STA                                    | TE, ZIP CODE  | •                             |                          |  |
| COLLEGE PARK REHABILITATION CENTER                  |  |  |            | 2856 E. CHEYENNE AVE.<br>NORTH LAS VEGAS, NV 89030 |   |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FUL<br>REGULATORY OR LSC IDENTIFYING INFORMATIO  |  |            | ID<br>PREFIX<br>TAG                                | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               | (X5)<br>COMPLETE<br>DATE |  |
| Z 000   | Initial Comments   |  |            | Z 000  |   |                               |                          |  |
|   | This Statement of Deficiencies was generated as a result of a re-licensure survey of the facility on March 24, 2009 through March 27, 2009.  The survey was conducted using Nevada Administrative Code (NAC) 449, Skilled Nursing Facilities Regulations, adopted by the Nevada State Board of Health on August 4, 2004.   |  |            |  |   |                               |                          |  |
|   |  |  |            |  |   |                               |                          |  |
|   | The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  The following regulatory deficiencies were identified:   |  |            |  |   |                               |                          |  |
|   |  |  |            |  |   |                               |                          |  |
| Z342<br>SS=B  | SS=B  NAC 449.74511 Personnel Records - Licenses, TB, Background  3. A current and accurate personnel record for each employee of the facility must be maintained at the facility. The record must include, without limitation: a) Evidence that the employee has obtained any license, certificate or registration, and possesses the experience and qualifications, required for the position held by the employee; b) Such health records as are required by chapter 441A of NAC which include evidence that the employee has had a skin test for tuberculosis in accordance with NAC 441A.375; and c) Documentation that the facility has not received any information that the employee has been convicted of a crime listed in paragraph (a) of subsection 1 of NRS 449.188. |  | ses,       | Z342   |   |                               |                          |  |
|   |  |  |            |  |   |                               |                          |  |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

PRINTED: 05/01/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS597S** 03/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2856 E. CHEYENNE AVE. **COLLEGE PARK REHABILITATION CENTER** NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z342 Z342 Continued From page 1 This Regulation is not met as evidenced by: Based on personnel record review, the facility failed to include documented evidence of physical examinations and completed Tuberculosis (TB) testing on 3 of 15 employees (#6, #7, #8). Findings include: Employee #6, hired on 7/15/08, revealed evidence of a negative chest X-ray on 2/23/09, however, the record did not contain evidence of a positive TB history and evidence of a signs and symptoms checklist was completed to ensure the absence of symptoms. Employee #7, hired on 12/1/08, revealed evidence of a negative chest X-ray dated on 7/20/07 and a signs and symptoms checklist dated 2/23/09. The review revealed no evidence of documentation of the employee's positive history of TB and an initial physical examination. Employee #8, hired on 11/11/08, revealed no evidence of an initial physical examination was completed. Severity: 1 Scope: 2 Z393 Z393 Personnel Training in Dementia

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

NAC 449.74522 Employees of facility which provides care to persons with dementia.

1. Except as otherwise provided in subsection 4, each person who is employed by a facility for skilled nursing which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, who has direct contact with and provides

SS=C

PRINTED: 05/01/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS597S** 03/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2856 E. CHEYENNE AVE. **COLLEGE PARK REHABILITATION CENTER** NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z393 Continued From page 2 Z393 care to persons with any form of dementia and who is licensed or certified by an occupational licensing board must complete the following number of hours of continuing education specifically related to dementia: (a) In his first year of employment with a facility for skilled nursing, 8 hours which must be completed within the first 30 days after the employee begins employment; and (b) For every year after the first year of employment, 3 hours which must be completed on or before the anniversary date of the first day of employment. 2. The hours of continuing education required to be completed pursuant to this section: (a) Must be approved by the occupational licensing board which licensed or certified the person completing the continuing education; and (b) May be used to satisfy any continuing education requirements of an occupational licensing board and do not constitute additional hours or units of required continuing education. 3. Each facility for skilled nursing shall maintain proof of completion of the hours of continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete continuing education pursuant to this section. 4. A person employed by a facility for skilled nursing which provides care to persons with any

form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of continuing education specifically related to dementia required pursuant to subsection 1 if he has completed that training within the previous 12

5. As used in this section, "continuing education specifically related to dementia" includes, without limitation, instruction regarding:

months.

PRINTED: 05/01/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS597S** 03/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2856 E. CHEYENNE AVE. **COLLEGE PARK REHABILITATION CENTER** NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z393 Continued From page 3 Z393 (a) An overview of the disease of dementia. including, without limitation, dementia caused by Alzheimer 's disease, which includes instruction on the symptoms, prognosis and treatment of the disease: (b) Communicating with a person with dementia; (c) Providing personal care to a person with dementia: (d) Recreational and social activities for a person with dementia: (e) Aggressive and other difficult behaviors of a person with dementia; and (f) Advising family members of a person with dementia concerning interaction with the person with dementia. This Regulation is not met as evidenced by: Based on personnel record review, the facility failed to ensure documentation of the required 8 hours of dementia training within the first 30 days of employment for 7 of 15 sampled employees (#1, #2, #6, #7, #8, #10, #14). Findings include: Employee #1, hired on 2/10/09, revealed no documented evidence of 8 hours of dementia training required within the first 30 days of training. Employee #2, hired on 7/28/08, revealed no documented evidence of 8 hours of dementia training required within the first 30 days of training. Employee #6, hired on 7/15/08, revealed no

documented evidence of 8 hours of dementia training required within the first 30 days of

PRINTED: 05/01/2009

FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS597S** 03/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2856 E. CHEYENNE AVE. **COLLEGE PARK REHABILITATION CENTER** NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z393 Continued From page 4 Z393 training. Employee #7, hired on 12/1/08, revealed no documented evidence of 8 hours of dementia training required within the first 30 days of training. Employee #8, hired on 11/11/08, revealed no documented evidence of 8 hours of dementia training required within the first 30 days of training. Employee #10, hired on 2/2/09, revealed no documented evidence of 8 hours of dementia training required within the first 30 days of training. Employee #14, hired 12/16/08, revealed no documented evidence of 8 hours of dementia training required within the first 30 days of training. Severity: 1 Scope: 3